DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
ASAM SUMMARY SHEET

(Section 1) Demographics and Status Request Today's Date: _____

Date of **most recent** ASI **completion**: _____ Appeal: Yes ☐ No ☐

Requesting Facility: _____

Date of **most recent** ASI **update** : _____ Insurance: Yes ☐ No ☐ Medicaid : Yes ☐ No ☐

Consumer last name (print): _____

First :_____ MI.:____

SS#: _____ DOB: _____ TASC Client: Yes ☐ No ☐ Unknown ☐

Assessor/Therapist: _____ Phone & ext.: _____

Status Request: ADMISSION ☐ CONTINUED STAY ☐ DISCHARGE/REFERRAL ☐

(Section 2) ***Current*** *Diagnosis*

Axis I _____

_____

_____

_____

_____

Axis II _____

_____

_____

_____

_____

Axis III _____

_____

_____

_____

_____

Axis IV _____

_____

_____

Axis V _____

Complete this form and fax to S.E.T. @ (302) 577-4860. Then call S.E.T. @ (302) 577-4479
Version 3.0, dated 8/01

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(Section 3) Show the alphanumeric and narrative description as applicable

1. Current ASAM Level: _____ Consumer's ASAM level of care request:_____

Recommended ASAM Level of Care (Indicate Facility if known): _____

2. ASAM Dimensions (Provide alphanumeric indicator and brief narrative for each dimension. Include progress/status as required. Detox: include Dimension 1 - Amount, Duration, and Last Use for each substance).

Dimension 1: _____

Dimension 2: _____

Dimension 3: _____

Dimension 4: _____

Dimension 5 :_____

Dimension 6: _____

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(Section 4) Complete as Appropriate

For continued stay, indicate number of additional days requested:

_____

For continued stay, indicate dates attended in last authorized period:

_____

For clients being discharged, indicate aftercare plan, living arrangements:

_____

_____

_____

Indicate reasons for discharge (i.e. Completed Tx, AMA) and **date of discharge**:

_____

_____

Comments:

_____

_____

_____

_____

_____ _____

Assessor/Therapist Name (please print) Clinical Supervisor Signature

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